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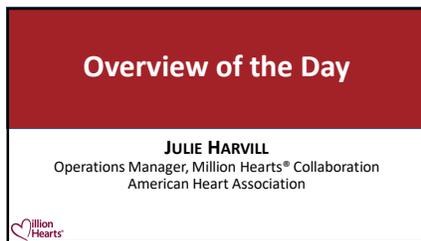
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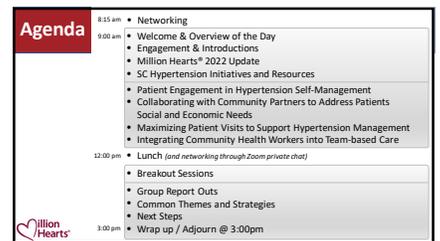
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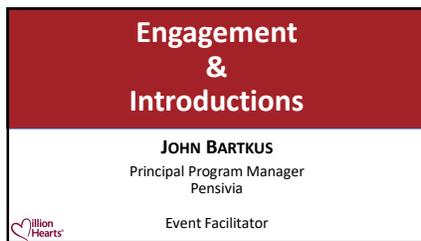
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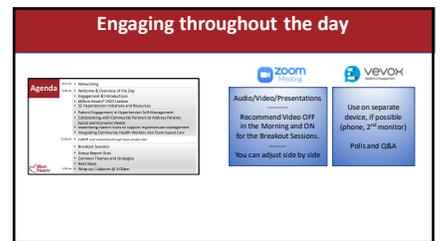
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Engaging throughout the day



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Where are you joining from today?



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Alignment and Connections



One of the sheets in your packet is "My Alignment Notes"

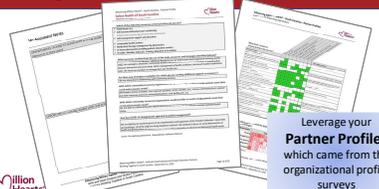
Opportunities I found to:

- Align with My Organization's work
- Align with Others' work

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Alignment and Connections



Leverage your **Partner Profiles** which came from the organizational profile surveys

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Introductions

Introduction Process

- Success requires Change of Approach!
- Let's see all the Organizations & Participants registered/participating!

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Million Hearts® 2022 Executive Director Update

LAURENCE SPERLING, MD, FACC, FACP, FAHA, FASPC
Executive Director, Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC
Center for Clinical Standards and Quality, CMS
Katz Professor in Preventive Cardiology
Professor of Global Health
Emory University

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Disclaimer/Disclosure



The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

Dr. Sperling has no conflicts to disclose.

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Million Hearts® Executive Director Update

- **Our hearts are focused on Millions across the Nation**
- **Cardiovascular Health and Prevention Remain a Priority**
- **Million Hearts® in Action**
 - Updates and Priorities
- Discussion / Q & A- following update on HCCP

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Our world has changed since January 28, 2020




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Impact of Pandemic on Cardiovascular Care (4/25/20)

The New York Times

Amid the Coronavirus Crisis, Heart and Stroke Patients Go Missing

Emergency physicians are warning that there is the number of patients waiting with cardiac conditions. Some say they were afraid to go to the hospital.

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Million Hearts® Executive Director Update

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Current Challenges / Concerns / Gaps in Care

- 118 M Americans living with Hypertension
- Disruption of Ambulatory care
- Need for Medication Access and Adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

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Khara A, et al. Am J Prev Cardiol 2020;1:1-10

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Impact of Pandemic (MMWR)

In the 10 weeks following the declaration of the COVID-19 national emergency, visits to emergency departments declined for:

- Heart attack: 23%
- Stroke: 20%
- Uncontrolled high blood sugar: 10%

People who are experiencing symptoms of fear or any life-threatening condition should seek immediate emergency care, even during the COVID-19 pandemic.

Hospitalizations were 6 times higher and deaths 12 times higher for COVID-19 patients with reported underlying conditions.

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<https://www.cdc.gov/mmwr/index.html>

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Implications of Delay and Disruption of Care During the Pandemic

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Khara A, et al. Am J Prev Cardiol 2020;1:1-10

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Recommendations for Patient Visits During Pandemic

- Don't defer patient visits
- Use telehealth including telephone – if at all possible
- At each visit:
 - Ask about symptoms
 - Encourage EMS/ER for concerning symptoms
 - Remind them that it is safe
 - Ensure adequate medication refills and access
 - Inquire about physical activity and nutrition habits
 - Use the full care team to enhance patient care

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Khara A, et al. Am J Prev Cardiol 2020;1:1-10

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SMBP- Vital Signs Vital for Telemedicine

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Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

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Schultz MN, Kell RM, Sankaranarayanan P, Quynh AA, Mearns GA, Spelling LS. Circulation. May 2016;133:2166-2178

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“In the midst of difficulty lies opportunity ...”

Albert Einstein

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Optimizing Opportunities

- Acceleration of New Care Models
 - Telehealth / telemedicine
- Decreased use of low-value care
- Volume to value transformation
- Healthcare integration / consolidation

Poppea A, et al. JACC 2020; 75(3):2989-2991
Khora A, et al. Am J Prev Cardiol 2020;1:1-10
Use [www.aha.org](#) ID: 136-377-847

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Million Hearts® 2022 Aim: Prevent a Million Heart Attacks and Strokes in Five Years

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Relative Event Contributions to "the Million"

Category	Relative Contribution (Estimated)
Appropriate	~100,000
Blood Pressure Control	~450,000
Cholesterol Management	~300,000
Smoking Cessation	~150,000
Physical Inactivity	~50,000
Sodium Reduction	~100,000

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Million Hearts® Executive Director Update

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Million Hearts® Hospitals & Health Systems Recognition Program

- A new program to recognize institutions working to improve the cardiovascular health of the population & communities they serve by:
 1. Keeping People Healthy
 2. Optimizing Care
 3. Improving Outcomes for Priority Populations
 4. Investing for Health
- Applicants apply online by **July 31, 2020** for the second quarter.
- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals and Health Systems
- **Apply today at** <https://millionhearts.aha.org/partners-locations/choose-your-partner-systems/apply>

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MH® Updates

- CDC-F Campaign (PSAs & beyond)
- Million Hearts 1.0 Addendum (\$5.6 B savings; 139K events)
- Hypertension Control Champions (118; 15M / 5 M)
- Cardiac Rehabilitation Think Tank
- AMAJ AHA Scientific Statement SMBP
- AMA validatebp.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package

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MH® Priorities

- Strategic Planning given current realities – Impact Document /
- Hypertension Control / Priority Populations (SG CTA / Hypertension Roundtable)
- National Association of Community Health Centers Hypertension Control / Cholesterol Management- statin videos (1400 / 24 M)
- Initiative focused on Nursing Partnerships (ORISE fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing internal/external relationships and partnerships (Maintain strong partnership with CMS & CMMI) ****Growth of new partnerships

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Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase of heart attacks and stroke.
- Flu vaccination is an AHA/AAC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to prevent heart attacks by 15% to 45% (a similar relative risk reduction as other guideline-directed medical therapy)

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Influenza (Flu) Burden and Vaccination

CDC estimates that, from October 1, 2019, through April 4, 2020, there have been:

30,000,000 - 36,000,000 Flu infections	18,000,000 - 26,000,000 Flu medical visits
410,000 - 740,000 Flu hospitalizations	24,000 - 42,000 Flu deaths

- Only 45% of adult Americans received flu vaccine during the 2018-2019 flu season
- There is a significant association between clinician recommendation and vaccination

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Summary Million Hearts® 2022 - Executive Director Update

- Heart disease and stroke remain leading causes of death in U.S.
- Cardiovascular Health and Prevention Must Remain a Priority
- Never a more important time to focus on Millions across the nation
- Commitment to collaboration, partnership, and perseverance

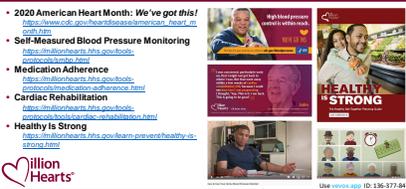


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Million Hearts® Resources

- 2020 American Heart Month: We've got this!**
<https://www.ahrq.gov/heart-month/>
- Self-Measured Blood Pressure Monitoring**
<https://millionhearts.hhs.gov/health-is-strong/>
- Medication Adherence**
<https://millionhearts.hhs.gov/health-is-strong/>
- Cardiac Rehabilitation**
<https://millionhearts.hhs.gov/health-is-strong/>
- Healthy is Strong**
<https://millionhearts.hhs.gov/health-is-strong/>




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A Million Thanks!



More on Million Hearts at [Millionhearts.hhs.gov](https://millionhearts.hhs.gov)
Reach me at L.Sperling@cdc.gov
Twitter @MillionHeartsUS



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Million Hearts® Hypertension Control Change Package

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

September 1, 2020



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Million Hearts® 2022 Priorities

Keeping People Healthy	Optimizing Care
Reduce Sodium Intake	Improve ABCs*
Decrease Tobacco Use	Increase Use of Cardiac Rehab
Increase Physical Activity	Engage Patients in Heart-Healthy Behaviors

Improving Outcomes for Priority Populations

Black/African Americans
35- to 64-year-olds
People who have had a heart attack or stroke
People with mental health or substance use disorders who use tobacco

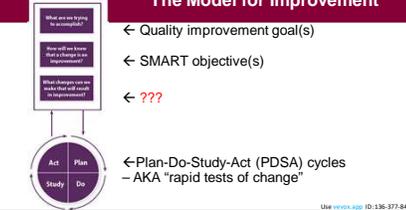
*AHA and other organizations. *Measures are in order of clinical management. Ranking not intended.



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The Model for Improvement



- ← Quality improvement goal(s)
- ← SMART objective(s)
- ← ???
- ← Plan-Do-Study-Act (PDSA) cycles
– AKA “rapid tests of change”

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Hypertension Control Change Package (HCCP) 2nd Edition, 2020



Access the Change Package at:
<https://millionhearts.hhs.gov/health-is-strong/protocols/action-package/2nd-edition-change-package/index.html>



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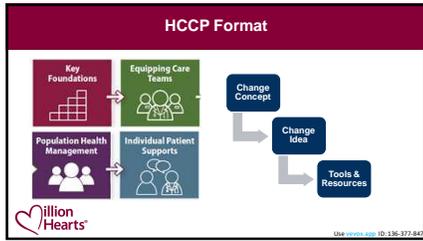
HCCP 2020

- Includes 253 tools from 87 organizations
- Capitalizes on 7 years of MH Hypertension Control Champions
- Features more self-measured blood pressure monitoring (SMBP) resources
- Explores potentially undiagnosed hypertension
- Added new strategies that focus on chronic kidney disease (CKD) testing and identification
- Provides more patient supports for lifestyle modifications

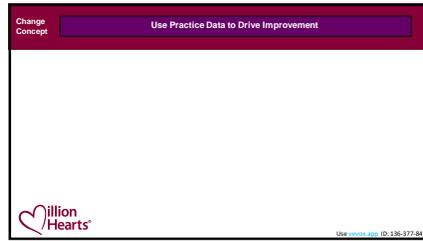


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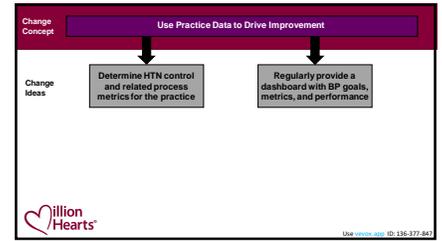
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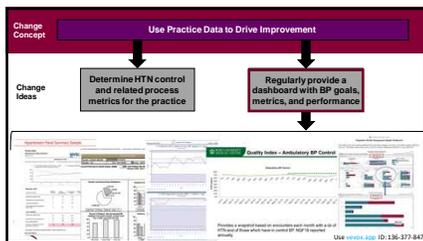
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Appendices – Additional Tools

- Additional Quality Improvement Resources
- Hypertension Control Case Studies

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What Can Public Health Do?

- Share the HCCP with clinical partners; incorporate into QI collaboratives
- Support optimization of HTN management into health care practice
- Share HTN messages on your social media profiles → #MillionHeartsQI
- Speak with partners about how they can do the same

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Q&A

Laurence Sperling, MD, FACC, FACP, FAHA, FASPC
Executive Director, Million Hearts*
LSperling@cdc.gov

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst, Million Hearts*
LOwens@cdc.gov

Division for Heart Disease and Stroke Prevention, CDC

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South Carolina Hypertension Initiatives and Resources

Katherine Plunkett Sr. Manager South Carolina Primary Health Care Association	Vonda Evans Community Impact Director American Heart Association	La'Shanda Wood Health Systems Specialist South Carolina Dept of Health & Environmental Control
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SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION

Access to Quality Health Care for all of South Carolina

South Carolina Primary Health Care Association

Katherine Plunkett, LMSW, MPH
Senior Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association

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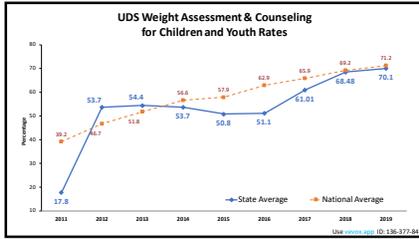
"Access to quality health care for all"

- SCPHCA TRAINING AND TECHNICAL ASSISTANCE INFRASTRUCTURE
 - Clinical Networks
 - Technical Assistance
 - Annual Clinical Network Retreat
 - SCPHCA First Thursdays CQI Webinar Series
- CLINICAL QUALITY INITIATIVES
 - Chronic Disease Management
 - Care Coordination with the Medical Neighborhood

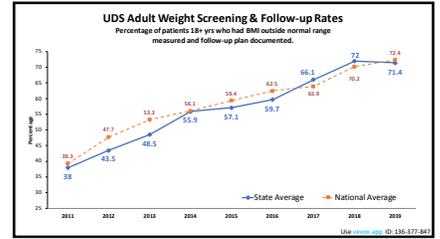


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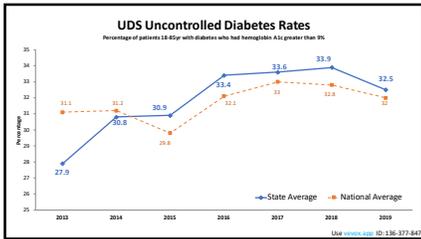
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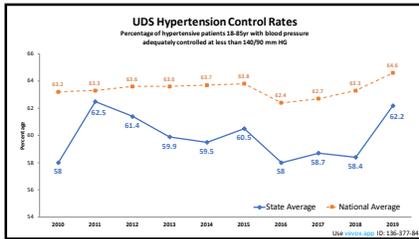
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AHA TOOLS TO IMPROVE QUALITY OF CHRONIC DISEASE MANAGEMENT

Advancing Million Hearts



Vonda Evans,
Community Impact Director

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Our MISSION STATEMENT

"To be a relentless force for a world of longer, healthier lives."



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MULTIPLE CHRONIC CONDITIONS (MCC)

> 1 in 4 Americans have 2+ concurrent chronic conditions including hypertension, diabetes, and heart disease
Prevalence of multiple chronic conditions among individuals increases with age.

As the number of chronic conditions ↑, the risks of the following outcomes also ↑:

- Mortality
- Poor functional status; unnecessary hospitalizations
- Adverse drug events; duplicative tests; conflicting medical advice.

66% of total health care spending is directed toward care for the approximately 27% of Americans with MCC.

Individuals with MCC face financial challenges related to:

- Out-of-pocket costs of care, including:
 - Higher costs for prescription drugs and total out-of-pocket health care

U.S. Department of Health and Human Services, Multiple Chronic Conditions—A Strategic Framework: Optimizing Health and Quality of Life for Individuals with Multiple Chronic Conditions. Washington, DC: September 2010



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THE RESULTING EFFORTS

TARGET: BP



All Programs

- Provide clinical guidelines and protocols
- Offer free resources for both providers and patients
- Connect clinical partners to others around the country engaged in the same work
- Offer recognition opportunities for any health care provider that demonstrates a commitment to, and/or achieve, clinical excellence.

Target: Type 2 Diabetes



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Factors impacting blood pressure control

Patient factors

- Nonadherence to treatment
- Lifestyle habits
- Lack of support for patients to self-manage HTN
- Social Determinants of Health

Physician factors

- Competing priorities/turns
- Subtle confidence/complacency
- Don't use evidence-based treatment protocol
- Diagnostic inertia
- Therapeutic inertia

Clinical inertia

System factors

Inaccurate Blood Pressure (BP) Measurements

- Lack of standardized measurement protocols, competency testing and retesting
- Creates uncertainty about reliability of BP

Not an organizational priority / lack of buy-in

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THE M.A.P. FRAMEWORK

MEASURE blood pressure accurately, every time.

ACT rapidly to address high blood pressure readings.

PARTNER with patients, families, and communities to promote self-management and monitor progress.

All 3 are critical for control

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TARGET: BP RESOURCES ON MEASURING ACCURATELY

- Technique quick check
- Positioning materials and quiz
- Webinars and case studies
- Resources to support home-monitoring

Technique quick-check

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SBMP helps patients and providers

Available resources:

- Training video*
- Infographic*
- SBMP recording logs
- General overview materials for patients

* SBMP monitoring helps patients better self-manage their high blood pressure and allows providers to diagnose and manage hypertension more effectively.

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ADDRESSING CHOLESTEROL

American Heart Association
Check. Change. Control.
Cholesterol™

American Heart Association
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RESOURCES WITHIN CCCC

- Tools for patients
- Tools for providers
- Guidance on ASCVD Risk Calculator
- Continuing Education Opportunities
- Newsletter
- Podcast Series

American Heart Association
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ADDRESSING DIABETES

American Heart Association
Target: Type 2 Diabetes™

Part of

Know Diabetes by Heart™

American Heart Association
Use www.heart.org ID: 136-377-847

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Know Diabetes by Heart™

Consumer Activation Campaign

Increase awareness and understanding of the connection between type 2 diabetes and cardiovascular disease.

Patient Resources & Support

A comprehensive portfolio of patient education, resources and self-management tools.

Professional Education & Support

Improve healthcare provider adherence to diabetes standards of care for management of CVD and CVD risk factors in patients with type 2 diabetes.

Quality & System Improvement

Implementing programs and activities to help health systems apply and practice the most up-to-date, evidence-based treatment guidelines for primary and secondary prevention of CVD and stroke events in patients with type 2 diabetes.

American Heart Association
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SAMPLING OF PROGRAM MATERIALS

www.knowdiabetesbyheart.org

Health Care Professional Tools and Resources

- Guidelines pocket guide
- ASCVD calculator
- Podcast series
- Webinar series
- Ask and Ask Scientific statements and guidelines
- Professional decks

Patient Education Materials (English and Spanish)

- Patient educational resources
- Discussion guide/summary email series
- Monthly "Ask the Experts" events
- ADA's "Living With Type 2" program

American Heart Association
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TARGET:BP
 American Heart Association
 Check Change Control
 Checkered
 Target: Type 2 Diabetes

Celebrating & Supporting
HEALTHCARE SYSTEM

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BENEFITS OF RECOGNITION

- An award certificate
- Digital award icons for use on your website and other materials
- Recognition toolkit including a press release template, social media messaging, and other communication resources
- National recognition on the Recognition Program website
- Recognition mentions at American Heart Association's annual Scientific Sessions meeting

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Questions or Assistance?

- Nora Farrell**
Community Impact Director, Upstate
Nora.Farrell@heart.org
ID: 864.448.3750 | M: 843.812.4188
- Vonda Evans**
Community Impact Director, Lowcountry
Vonda.evans@heart.org
ID: 843.480.4972 | M: 843.817.0990
- Cynthia Okland**
Executive Director, Midlands
Cynthia.Okland@heart.org
ID: 803.600.3020

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Join: [vevox app](#) ID: 136-377-847 **POLL OPEN**

What percent of South Carolina adults have high blood pressure?

- 55.6%
- ✓ 38.1%
- 25.3%
- 66.2%

Million Hearts

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American Heart Association
 Advancing Million Hearts
 Heart Disease and Stroke Prevention Partners Working Together in South Carolina
 LaShanda Wood
 Health System Specialist
 Division of Diabetes and Heart Disease Management
South Carolina Department of Health and Environmental Control
[Healthy People. Healthy Communities.](#)

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dhec South Carolina Department of Health and Environmental Control
 Healthy People. Healthy Communities.

DHEC Vision, Mission and Core Values

- Vision:** Healthy people living in healthy communities
- Mission:** To improve the quality of life for all South Carolinians by protecting and promoting the health of the public and the environment
- Core Values**
 - Embracing Service
 - Inspiring Innovation
 - Promoting Teamwork
 - Pursuing Excellence

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dhec South Carolina Department of Health and Environmental Control
 Healthy People. Healthy Communities.

Division of Diabetes and Heart Disease Management

- Our Focus
- Our Funding
- Our People

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South Carolina Data

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 Healthy People. Healthy Communities.

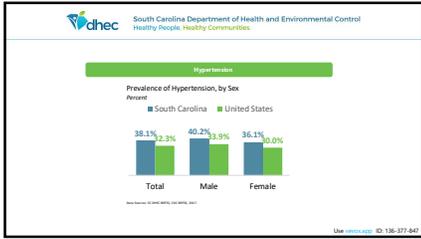
Hypertension

Prevalence of Hypertension, by Race/Ethnicity

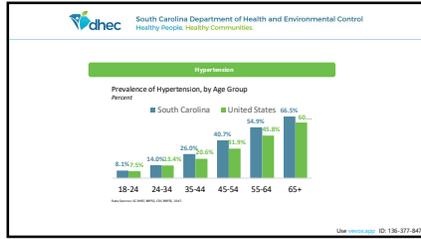
Race/Ethnicity	South Carolina	United States
non-Hispanic White	36.9%	33.3%
non-Hispanic Black	45.8%	39.9%
Hispanic	19.4%	22.6%

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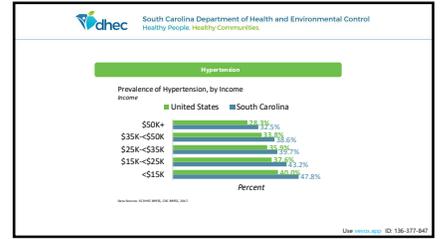
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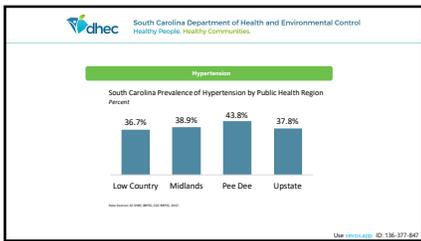
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Our Approach

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- ### Intended Outcomes
- Promote identification of patients with undiagnosed hypertension.
 - Increase the use of self-measured blood pressure monitoring (SMBP) with support from the Provider and Care Team.
 - Promote the adoption and use of electronic health records (EHR) and health information technology (HIT) to improve provider outcomes and patient health outcomes related to identification of individuals with undiagnosed hypertension and management of adults with hypertension.
 - Expand and increase the utilization of Pharmacists and other team members in team-based care to reduce, control, and monitor blood pressure.

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- ### Hypertension Prevention and Management in South Carolina
- Health Systems Interventions
 - Clinical-Community Linkages
 - Provider Engagement

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- ### Health Systems Interventions
- Systems level approach
 - Policy development
 - Integration of pharmacists into primary care settings utilizing the hybrid model of care to promote Medication Therapy Management

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Community-Clinical Linkages

We utilize community-clinical linkages to prevent and manage hypertension by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live.

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Healthy People. Healthy Communities.

Provider Engagement

- Successfully engaging providers and their staff can have a dramatic impact on the patient provider health experience
- Involved providers lead to improved clinical outcomes

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Collaborative Partners

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Healthy People. Healthy Communities.

Partners in Hypertension Prevention and Management

- Centers for Disease Control and Prevention (CDC)
- South Carolina Pharmacy Association (SCPhA)
- South Carolina Primary Healthcare Association (SCPHCA)
- South Carolina Office of Rural Health (SCORH)
- The American Society of Hypertension (ASH)
- The American Heart Association (Advancing Million Hearts)
- South Carolina Alliance of YMCAs

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CONTACT US

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(803)-898-0762

Stay Connected

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Q&A Combined

<p>Katherine Plunkett Sr. Manager South Carolina Primary Health Care Association</p>	<p>Vonda Evans Community Impact Director American Heart Association</p>	<p>La'Shanda Wood Health Systems Specialist South Carolina Dept of Health & Environmental Control</p>
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Stretch Break

2:00 mins

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Develop strategies for increasing patient engagement and activation in hypertension self-management

DANIEL T. LACKLAND, DRPH, FACE, FAHA
Medical University of South Carolina

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Disclosures

- Member of NHLBI Risk Assessment Workgroup
- Member of 2014 Hypertension Guidelines (JNC 8)
- Member of Evidence Rating Committee for ACC/AHA Hypertension Guidelines
- No financial disclosures

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IMPACT: PREVALENCE OF HYPERTENSION – 2017 ACC/AHA AND JNC7 GUIDELINES

Guideline	Prevalence (%)	Number of US adults with hypertension (millions)
JNC7	31.9%	72.2
2017 ACC/AHA	45.13.7%	103.1

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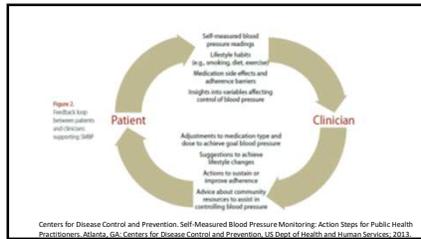
99

Use out-of-office BP measurements to confirm the diagnosis of hypertension and to titrate antihypertensive medication in conjunction with telehealth counseling or clinical interventions.

- Using a combination of office and out-of-office BP measurements, several useful BP patterns can be discerned.
- Data indicate that masked hypertension and masked uncontrolled hypertension are associated with high risk of CVD and mortality.
- Likewise, telehealth can be employed with valid out of clinic blood pressure vales.

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Home Blood Pressure Monitoring

- HBPM can be used to detect white-coat hypertension and masked hypertension.
- Many HBPM devices available for purchase have not been validated, and **only validated devices should be recommended for HBPM.**
- HBPM is effective in reducing BP when used in combination with supportive interventions (eg, web/telephone feedback).
- Patients should be encouraged to use HBPM devices that automatically store BP readings in memory or transmit BP readings to a healthcare provider

Hypertension. 2019;73:e35-e66. Use [www.aaha.org](#) ID: 136-377-847

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Patient training provided by healthcare staff or providers

- Provide information about **hypertension diagnosis and treatment**
- Provide information on the **proper selection of a device**
- Provide instruction on **how patients can measure their own BP**
- Provide instruction that the **HBPM device and BP readings should be brought to healthcare visits**
- Provide education that **individual BP readings may vary greatly (high and low) across the monitoring period**

Hypertension. 2019;73:e35-e66. Use [www.aaha.org](#) ID: 136-377-847

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Preferred devices and cuffs

- Use an upper-arm cuff oscillometric device that has been validated
- Use a device that is able to automatically store all readings
- Use a device that can print results or can send BP values electronically to the healthcare provider
- Use a cuff that is appropriately sized for the patient's arm circumference

Hypertension. 2019;73:e35-e66. Use [www.aaha.org](#) ID: 136-377-847

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Best practices for the patient preparation

- Have an empty bladder
- Rest quietly in seated position for at least 5 min
- Do not talk or text
- Position Sit with back supported and both feet flat on the floor
- BP cuff should be placed on a bare arm (not over clothes)

Hypertension. 2019;73:e35-e66. Use [www.aaha.org](#) ID: 136-377-847

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Actions to Prepare Care Teams to Support SMBP

- Standardize training of clinicians to take blood pressure readings and teach SMBP techniques to their patients.
- Conduct an initial clinician competency exam for pertinent staff and new employees to demonstrate proper technique in:
 - Cuff selection
 - Patient positioning
 - Measurement without talking
 - Accurate observation of the blood pressure level
 - Consider additional competency training for all employees at regular intervals.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2014. Use [www.aaha.org](#) ID: 136-377-847

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Actions to Prepare Care Teams to Support SMBP

- Train relevant **team** members (e.g., PAs, NPs, nurses, pharmacists) to lead the clinical support piece of SMBP interventions.
- Clinical support programs should be delivered only by clinicians specifically trained for the intervention.
- Incorporate this clinical support into existing disease management programs.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2014. Use [www.aaha.org](#) ID: 136-377-847

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Actions to Empower Patients to Use SMBP

- Discuss with your patients
- Review the types of available SMBP devices and work with patients to choose the best option.
- Check the home device for accuracy by comparing readings to a reliable office device.
- Train patients on proper SMBP technique. Explain:
 - How to operate the device.
 - Patient preparation.
 - Proper positioning and technique.
 - When to measure BP (time of day/frequency).
- Patients should communicate all BP records to a clinician.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2014. Use [www.aaha.org](#) ID: 136-377-847

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Home Blood Pressure Monitors

Table 5. Preferred Characteristics of a Home Blood Pressure Monitor*	
Preferred	Not Preferred
Automated	Manual
Upper arm cuff	Wrist cuff†
Regularly sized cuff	Too large or too small cuff
Memory storage capacity	No memory storage
Printing capacity	No printer
Ability to upload BP readings to computer or other electronic device	No ability to upload
Accuracy checked by clinician after purchase	Patient uses monitor without consulting clinician

*Wrist cuff may be used as a provision for patients who are obese or have other difficulties using upper arm cuffs, but the accuracy of readings may be inaccurate.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2014. Use veeva app ID: 136-377-847

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Table 2. Corresponding Values of Clinic, Home, Daytime, Nighttime, and 24-Hour BP Measurements (2017 American College of Cardiology/American Heart Association Guidelines)

Clinic	HBPM	Daytime ABPM	Nighttime ABPM	24-Hour ABPM
120/80	120/80	120/80	100/65	115/75
130/80	130/80	130/80	110/65	125/75
140/90	135/85	135/85	120/70	130/80
160/100	145/90	145/90	140/85	145/90

ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; and HBPM, home blood pressure monitoring.

Hypertension. 2019;74:229-236. Use veeva app ID: 136-377-847

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Conclusions

- Self-Monitored Blood Pressure and Home Blood Pressure Monitoring are critical components of team-based hypertension management.
- The SMBP and HBPM values must be valid and trusted by the Team in order to have impact.

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Q&A

DANIEL T. LACKLAND, DRPH, FACE, FAHA
Medical University of South Carolina

Million Hearts Use veeva app ID: 136-377-847

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Collaborating with Community Partners to Address Patients Social and Economic Needs

TRICIA RICHARDSON
CEO
SC Thrive

Million Hearts Use veeva app ID: 136-377-847

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sc Thrive

Collaborating to Address SDoH

September 1, 2020

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- Family Reunification
- Employment
- Recovery
- Housing
- Food

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We Have the Resources



People in Need Integrated Support Community Partners Service Providers

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The Vision: Dedicated Partners for Community Health

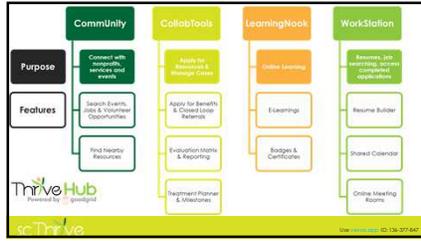


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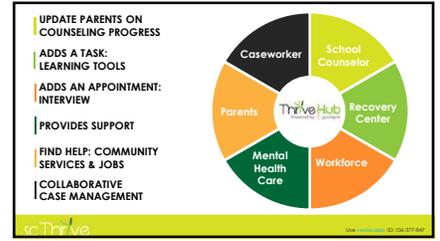
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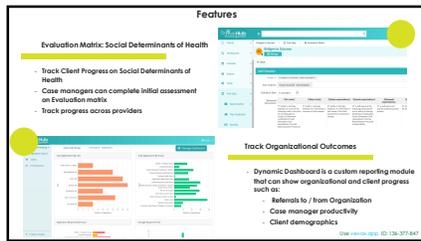
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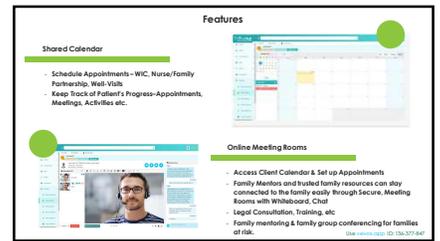
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Q&A

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Q&A

TRICIA RICHARDSON
 CEO
 SC Thrive



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Maximizing Patient Visits to Support Hypertension Management

CRYSTAL A. MAXWELL MD, MBA, FAAFP
 Chief Medical Officer/Family Physician, Sandhills Medical Foundation, Inc.

EDWARD BEHLING, MD, FAAFP
 Chief Medical Officer

TAMMY GARRIS
 Clinical Data Integrity Controller
 HopeHealth



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Improving Hypertension Control

Maximizing patient visits to support hypertension management

Crystal A. Maxwell, MD, MBA, FAAFP
Chief Medical Officer

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The Measure

- Hypertension: Blood pressure control <140/90
- DESCRIPTION: % of patients 18 - 85 y/o with hypertension who had blood pressure <140/90 during the measurement period
- IMPROVEMENT NOTATION: Higher score indicates better quality
- INITIAL POPULATION: Patients 18 - 85 y/o with hypertension with a visit during the measurement period
- DENOMINATOR: Equals Initial Population
- NUMERATOR: Patients whose most recent blood pressure <140/90

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SMF 2011-2014 Data

Health Center	% of patients 18 - 85 y/o with hypertension who had blood pressure <140/90 during the measurement period			
	2011	2012	2013	2014
Sandhill Medical Foundation, Inc.	51%	48%	55%	64%

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IMPACT



IMPACT: Improving Patient Management And Control Through Hypertension

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Quality Improvement

- 2013 received PCMH accreditation via NCQA
 - 2011-2013 began assessing process and coordinating uniform processes at all sites
- 2013 Quarterly Clinician bonuses initiated
 - 6 quality measures (diabetes, hypertension, breast cancer screening, cervical cancer screening, colon cancer screening, pneumonia vaccination)
 - 2 Additional: Closing out charts and Meeting attendance

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Managing Barriers

- PDSA Cycles completed 2014-2017
- Barriers found:
 - Not taking meds before visits
 - Proper BP measurements
 - Data inaccuracies
 - Variation in follow up among clinicians
 - Medication compliance

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IMPACT!

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Methods

- Education
 - Reviewed proper blood pressure measurement technique with nursing staff
 - Reviewed proper documentation of repeat bp reading
 - Added blood pressure measurement review to nursing yearly skills check
- Visits
 - Reminded patients to take meds before each visit unless specifically told to fast
 - Nursing staff instructed to repeat bp check if bp \geq 140/90
 - Blood pressure log given at visits
 - Care plan with blood pressure goals and medication list given at visits
 - Clinical summary showing changes in medications given at visits

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Methods

- Visits cont.
 - Encouraged Clinicians to schedule nurse blood pressure checks 1-2 weeks after the visit if bp \geq 140/90
 - Clinicians cautioned on quantity of refills prescribed if bp uncontrolled
 - Patients instructed to take meds at least 1-2 hours before nurse visit
 - Red flagged message sent to Clinician during nurse visit if bp \geq 140/90 for management
 - Clinician may work in patient
 - Clinician may send instructions for med change
 - Clinician instructs next follow up

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Change



Change is hard at first, messy in the middle and gorgeous at the end.

Simple Membership

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SMF 2015-2019 Data

Health Center	# of patients 18 - 85 y/o with hypertension who had Mead pressure <140/90 during the measurement period				
	2015	2016	2017	2018	2019
SandHills Medical Foundation, Inc.	68%	66%	72%	76%	77%

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TEAMWORK



"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

— [Simon Sinek](#)

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- ### Best Practice Ideas
- Review and use data
 - Utilize FDSA
 - Reward those who are doing the work
 - Don't over look systolic readings of 140 or diastolic readings of 90
 - Integrate methods into workflow
 - Utilize nurse visits for closer follow up with Clinical involvement if not at goal
 - Caution number of refills provided to those not at goal
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IMPACT

- Integrate
- Methods
- Purposefully
- And
- Change
- Translates



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Questions? Submit on Vevox for Q&A



A **life** is not important except in the **impact** it has on **other lives.**

— Jackie Robinson —

AZ Q&A

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Maximizing Patient Visits to Support Hypertension Management

<p>CRYSTAL A. MAXWELL MD, MBA, FAAFP Chief Medical Officer/Family Physician, Sandhills Medical Foundation, Inc.</p>	<p>EDWARD BEHLING, MD, FAAFP Chief Medical Officer TAMMY GARRIS Clinical Data Integrity Controller HopeHealth</p>
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Optimizing Patient Visits to Support Hypertension Management

Edward Behling, MD, FAAFP
Tammy Garris, Clinical Data Integrity



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Our Metrics

Measure	2019
Blood Pressure at every Visit	93.7%
Statin Therapy for Prevention & Treatment of CVD	78.9%
Undiagnosed HTN	13.1%
Essential HTN Prevalence	45.1%
HTN Prevalence	51.0%



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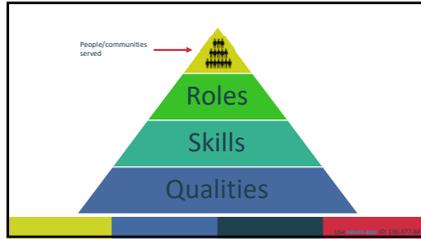
Who are CHWs?

American Public Health Association definition:

- A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as an intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
- A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.



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CHW Qualities: the most important thing

- Trusted member of community
- Integrity
- Connected/Resourceful
- Persistent
- Relationship Builder
- Flexibility
- Compassion
- Dedication
- Team Player

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Core CHW roles

- Bridge building: Individuals, communities, health care system
- Culturally appropriate health education and information
- Care coordination, case management, system navigation
- Coaching, social support
- Advocating for individuals and communities
- Building community capacity
- Direct services: enrollment, resources
- Assessments
- Outreach
- Evaluation and outreach

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WHY CHWs NOW?

- Increasing spending on healthcare without improved results
- Workforce shortages
- Move to value-based care
- Recognition of importance of addressing social determinants and non-medical needs
- Ability to fill gaps in care not filled by others as part of the care team

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The Need for More CHWs in order to Impact Health

Recent Mentions-South Carolina

- SC INSTITUTE OF MEDICINE AND PUBLIC HEALTH'S WORKFORCE FOR HEALTH WORKFORCE
- SC OFFICE OF RURAL HEALTH'S RURAL HEALTH ACTION PLAN
- ALLIANCE FOR A HEALTHIER SOUTH CAROLINA'S HEALTH CARE POLICY

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CHWs in SC now

- CHWs in some FQHCs, some Access Health Networks, community-based organizations (Birth Matters, Healthy Start, PASOs), employed by some health systems and MCOs.
- Mostly paid for by grants, a few by hospital operating funds, some as part of FQHC operating funds, a couple MCOs.
- Founding of SCOWA in 2015
- Community Health Worker Institute- as of March, 2019
- CHW Credentialing Council: April, 2019; SC core competencies, able to approve curricula for certifying CHWs, setting workforce standards.

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CHW data in SC

- Access Health: most use CHWs; 21% reduction in inpatient costs, 29% reduction in ED costs
- PASOs: 82% success rate in improving access to care and resolving SDOH issues
- Family Solutions of the Lowcountry: 65% reduction in African American infant mortality rate
- Birth Matters: Saved Spartanburg over \$1.4 million through decreased C-sections and NICU admissions
- Care South: CHWs on care teams—46% decrease in ER; all HEDIS measure including well-child up 17.5%
- CHWIRFP for ROI: 5 projects participating in study from 2020-2022

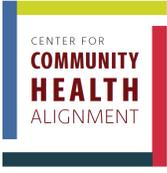
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National CHW Evidence: a snippet

- Multiple studies have found CHW programs are effective at decreasing **HbA1c levels** in participants with diabetes and **improve blood pressure**.
- Clinical trials of a standardized CHW model have shown consistent improvements in **mental health**, patient-reported **quality**, and **access to care**, along with a **65% reduction in hospital days**. The cost savings translate into a 2:1 return on investment.
- BSS** in rural Arkansas: reduction in claims and payment after CHW intervention—**4:1 ROI**.
- Pediatric asthma**—CHWs reduced asthma symptom days and urgent health services use
- Increased cervical and breast cancer **screenings**

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UofSC Arnold School of Public Health
Center for Community Health Alignment



CENTER FOR
COMMUNITY HEALTH
ALIGNMENT

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Training and Curriculum Development

- High quality core competency training to CHWs based on national and state standards
- Strong focus on skills and social determinants
- CHW Supervisor Training
- Continuing Education
- Specialty Tracks: MCH, LGBTQ, rural health, chronic disease, oral health, others
- Train-the-Trainer model for statewide training availability
- Rigorous field program

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TECHNICAL ASSISTANCE

- Training and technical assistance to health and other organizations on developing CHW programs
- Integration of CHWs into models of practice and health delivery teams utilizing best practices
- CHW data extraction, data set development and evaluation design
- Development of a CHW Toolkit
- Best practice expertise informed by Best Practices Experts Council

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EVALUATION

- CHWI is collaborating with five pilot sites in SC to evaluate the ROI for systems of care utilizing the CHW model
- The five programs are being evaluated for approximately two years. Data will be collected and analyzed on outcomes related to patient health outcomes, upstream prevention activities, social determinants of health, health education and behavior change, patient engagement, and others.
- Data Experts Council: think tank focused on data collection and data for CHW planning



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Development of Reimbursement/Payment Models

The Institute is working with current and potential payers to determine the feasibility of new models to cover CHW services. Partners include: SCFHCA, DHHS, SCHA, MCOs, The Duke Endowment, BCBS of SC, BCBS Foundation of SC, the Alliance, DHEC.

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Q&A

Contact Information

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<https://scchwa.org/>

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Lunch & Networking

Use Zoom Private Chat to Connect

Meeting Resumes at 12:30 pm

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Kickstart to Resume

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Afternoon Breakouts / Facilitated Discussions

JOHN BARTKUS
Principal Program Manager
Pensavia

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Breakout Workgroups

Breakout Session Topics	Groups
Increasing Patient Engagement	1A, 1B, 1C
Collaborating with Community Partners	2A, 2B
Maximizing Patient Visits	3A

1:55pm

2:05pm ET

Breakout Session
75 mins

Report Outs
2 mins each

Common Themes

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Workgroup Objectives

What is each organization doing? What's working? What isn't? What can be shared? What's Next?

Group Discussion (Focused on Five Key Questions) for your Topic:

1. What's **WORKING WELL**? (~15 mins)
2. What are the **KEY CHALLENGES**? (~15 mins)
3. How might we **ADDRESS THESE CHALLENGES**? (~15 mins)
4. What other **OPPORTUNITIES** do we have? (~15 mins)
5. What do we choose to **DO NEXT**? (~10 mins)

Individual Take-aways: (~5 mins)

- What new strategy did I learn today?
- What new partners have I identified today with whom I can work to further my/their goals?
- What are two things I can implement to employ new patient engagement strategies?

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Workgroup Mechanics

Main Zoom Room

1A

1B

1C

2A

2B

3A

- You've been **pre-assigned** to a session based on your topic choice.
- In a few moments – you'll see a **popup** to join your session.
- At the end of the session, you'll **automatically return** to the main room. (No need to do anything)

1:55pm

2:05pm ET

Breakout Session
75 mins

Report Outs
2 mins each

Common Themes

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Breakouts In Progress

Main Zoom Room

1A

1B

1C

2A

2B

3A

- If you're seeing this slide, it means you're still in the main room.
- Let John Barkus know if you want to join one of the breakout sessions.

1:55pm

2:05pm ET

Breakout Session
75 mins

Report Outs
2 mins each

Common Themes

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Group Report Outs

Breakout Session Topics	Groups
Increasing Patient Engagement	1A, 1B, 1C
Collaborating with Community Partners	2A, 2B
Maximizing Patient Visits	3A

Order of Report outs...

1A

2A

1B

2B

1C

3A

Short break now.
Report outs Start at 2:05 pm ET

In

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Common Strategies and Themes

SHARON NELSON

Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association

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Next Steps

SARAH MILLER COCKRELL

Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association

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Adjourn

JOHN CLYMER

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